

Effective Date: January 12, 2011

CRITERIA FOR PRIOR AUTHORIZATION

Ecallantide (Kalbitor®)

PROVIDER GROUP: Pharmacy
Professional

MANUAL GUIDELINES: The following drug(s) require prior authorization:
Ecallantide (Kalbitor®)

CRITERIA for Ecallantide: (must meet all of the following)

- Patient must be 16 years of age or older.
- Patient must have a diagnosis of hereditary angioedema (HAE).
- Must be used for the treatment of an acute attack of HAE.
- Must be administered by a healthcare professional.

Prior authorization will be approved for 6 (six) months.